WISCONSIN MEDICAID
PRIOR AUTHORIZATION / DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA) Completion Instructions (HCF 11030A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Prescribing Physician

5. Prescribing Physician's Medicaid Provider No.

6. Telephone Number — Prescribing Physician

7. Telephone Number — Dispensing Provider

SECTION III — SERVICE INFORMATION

8. Describe the overall physical status of the recipient (mobility, self-care, strength, coordination).

9. Describe the medical condition of the recipient as it relates to the equipment / item requested (e.g., describe why the recipient needs this equipment).

10. Is the recipient able to operate the equipment / item requested?

❑ Yes ❑ No — If not, who will do this?

Continued

SECTION III — SERVICE INFORMATION (Continued)

11. Is training provided or required?

❑ Yes ❑ No — If not, who will do this?

Explain:

12. State where equipment / item will be used.

❑ Home ❑ Office
❑ Nursing Home ❑ Job
❑ School

Describe type of dwelling and accessibility.

13. State estimated duration of need.

14. If renewal or continuation of DME authorization is requested, describe the following about the recipient, including current clinical condition, progress (improvement, no change, etc.), results, and the recipient's use of equipment / item prescribed.

15. Indicate amount of oxygen to be administered.

____ Liters per minute ____ Continuous
____ Hours per day ____ PRN
____ Days per week ____ PaO_2

Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated within six months of receipt by Wisconsin Medicaid.

16. **SIGNATURE** — Requesting Provider	17. Date Signed

Reset Form